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15-35, 15-105, 15-119, and 15-191

IN THE

Supreme Court of the United States

DAVID A. ZUBIK, ET AL., PETITIONERS

v.

SYLVIA BURWELL,
SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

On Writs of Certiorari
to the United States Courts of Appeals
for the Third, Fifth, Tenth, and D.C. Circuits

BRIEF OF THE GUTTMACHER INSTITUTE AND PROFESSOR SARA ROSENBAUM AS AMICI CURIAE IN SUPPORT OF THE GOVERNMENT

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BRIEF OF THE GUTTMACHER INSTITUTE AND PROFESSOR SARA ROSENBAUM AS AMICI CURIAE IN SUPPORT OF THE GOVERNMENT

This brief is submitted on behalf of the Guttmacher Institute and Professor Sara Rosenbaum as amici curiae in support of the government.[1]

INTEREST OF AMICI CURIAE

Amici are the Guttmacher Institute and Professor Sara Rosenbaum.

Now in its fifth decade, the Guttmacher Institute is a nonprofit, nonpartisan corporation and a leading research and policy organization dedicated to advancing sexual and reproductive health and rights in the United States and globally. The Institute's overarching goal is to ensure quality sexual and reproductive health for all people worldwide by promoting evidence-based policies and conducting research according to the highest standards of methodological rigor. It produces a wide range of resources on topics pertaining to sexual and reproductive health and publishes two peer-reviewed journals. The information and analysis it generates on reproductive rights issues are widely cited by policymakers, the media and advocates across the ideological spectrum.

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[1] No counsel for any party authored this brief in whole or in part, and no person other than amici or their counsel have made any monetary contribution intended to fund the preparation or submission of this brief. Letters from all parties consenting to amici briefs are on file with the Clerk's office.

Professor Rosenbaum is the Harold and Jane Hirsh Professor of Health Law and Policy at The Milken Institute School of Public Health, George Washington University, where she also holds appointments in the University's Schools of Law and Medicine. Professor Rosenbaum has focused her career on issues of health and health equity for all Americans. Her expertise lies in public and private health insurance and its role in ensuring access to affordable, high-quality preventive, primary, and specialized health care, especially in the case of women and children. A member of the National Academy of Medicine and a former member of the Guttmacher Institute's board of directors, Professor Rosenbaum enjoys wide recognition in her field. She has authored over 100 peer-reviewed journal articles and is the leading author of *Law and the American Health Care System* (2d edition), which offers a panoramic legal overview of health care access, financing, and quality, as well as a comprehensive discussion of law and women's health. Professor Rosenbaum's work helped inform the design and implementation of the Affordable Care Act.

Amici have a strong interest in the resolution of this case. In particular, amici write to share the extensive empirical evidence that effective family planning yields enormous societal benefits for American women, children, and families, and that the contraceptive-coverage guarantee at issue in this case is crucial to achieving those benefits.

INTRODUCTION AND SUMMARY OF ARGUMENT

The contraceptive coverage guarantee of the Affordable Care Act (ACA) allows women to choose the best, most effective methods of contraception for their needs, consistent with their own religious and moral values. Removing cost barriers to effective contraception provides women equal access to essential health care, reduces women's risk of unintended pregnancy, decreases the need for abortion, promotes women's education and workforce participation, and enhances the health and economic security of women and families. The extraordinary importance of effective contraception led the federal Centers for Disease Control and Prevention to name improved family planning one of the ten great public health achievements of the 20th Century.

Without the contraceptive coverage guarantee, cost would be a major factor for women choosing among different methods of contraception. Empirical evidence demonstrates that cost concerns drive women towards methods that are far less effective in preventing pregnancy. For example, a hormonal intrauterine device ("IUD") is *90 times more effective* than male condoms in preventing pregnancy during the first year of typical use. Yet while male condoms are relatively cheap and widely available, an IUD can cost a month's salary for a woman working full time at minimum wage, and women who face high out-of-pocket IUD costs are significantly less likely to obtain one.

The ACA's contraceptive coverage guarantee helps privately insured women access their choice of

contraceptive methods without such cost constraints. Extensive evidence demonstrates that removing cost barriers improves women's access to effective contraception and reduces women's risk of unintended pregnancy.

The accommodations offered by the government ensure that women can obtain contraceptive services from their regular health care providers as part of their regular medical care, while putting no burden on objecting employers to provide or pay for that coverage. No other option can further the government's compelling interests as effectively.

The alternatives that petitioners propose would put the burden on individual women to seek and secure additional contraceptive coverage. As studies have proven consistently across a wide variety of contexts, placing the burden on individuals to "opt in" dramatically undermines the effectiveness of programs. Petitioners' alternatives would decrease the overall use of the most effective methods of contraception, stigmatize contraceptive services, and erect financial and logistical obstacles to care that could deny women the ability to receive care from their desired provider at the same time they receive other relevant care.

The government has for decades demonstrated its commitment to giving women access to family planning services and supplies as part of comprehensive and integrated insurance coverage. Judge Brett Kavanaugh summed up the benefits well: "Reducing the number of unintended pregnancies would further women's health, advance women's personal and professional opportunities, reduce the number of abor-

tions, and help break a cycle of poverty that persists when women who cannot afford or obtain contraception become pregnant unintentionally at a young age."[2] The ACA's contraceptive coverage guarantee is the least restrictive means of furthering these compelling interests.

ARGUMENT

I. ELIMINATING BARRIERS TO EFFECTIVE CONTRACEPTIVE USE REDUCES THE RISK OF UNINTENDED PREGNANCY.

Half a century ago, this Court recognized the right to use contraception in *Griswold v. Connecticut*.[3] In 1992, the Court noted the by-then familiar benefits that had accrued to women and society: "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[4] And as five members of this Court recognized just two years ago, the ACA's contraceptive coverage guarantee serves the government's "legiti-

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[2] *Priests for Life v. U.S. Dep't of Health & Human Servs.*, 808 F.3d 1, 22-23 (D.C. Cir. 2015) (Kavanaugh, J., dissenting from the denial of reh'g en banc) (footnote omitted).

[3] 381 U.S. 479 (1965).

[4] *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 856 (1992).

mate and compelling interest in the health of female employees."[5]

Petitioners make only the faintest effort to argue access to contraception is not actually important to women and society, devoting only a single footnote citing a single law review article to the topic in their combined 160 pages of opening briefs.[6] And for good reason. Contrary to the claims of some of the petitioners' amici, the federal contraceptive coverage guarantee does not force individual women to do anything they do not want to do. Rather, it advances women's ability to make fundamental choices about whether and when to have children, which in turn advances the health, social, and economic well-being of women and their families.

A typical American woman wishing to have only two children must, on average, spend three decades—roughly 90% of her reproductive life—avoiding unintended pregnancy.[7] Virtually all women, across a variety of religious affiliations, have

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[5] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2786 (2014) (Kennedy, J., concurring); *id.* at 2799-2800 (Ginsburg, J., dissenting).

[6] Eastern Texas Baptist University (ETBU) Br. 60 n.7. The primary argument of both sets of petitioners is that the ACA's exemptions somehow demonstrate that the government does not view contraception as a compelling interest, but petitioners misunderstand the nature of both the exemptions and the compelling interest test. *See* U.S. Br. 54-72.

[7] ADAM SONFIELD ET AL., GUTTMACHER INST., MOVING FORWARD: FAMILY PLANNING IN THE ERA OF HEALTH REFORM 7 fig.1.2 (2014), *available at* http://www.guttmacher.org/pubs/family-planning-and-health-reform.pdf.

used at least one method of contraception.[8] In practice, however, methods of contraception are not all equally effective or appropriate. Currently, about half of all pregnancies in the United States are unintended,[9] and 40% of unintended pregnancies end in abortion.[10]

Vital to making abortion less necessary is empowering women to prevent unintended pregnancy in the first place. That depends on a woman's ability to choose and consistently use the method of contraception most appropriate to her needs, in consultation with her health care provider, unhampered by cost concerns that often drive women toward less effective methods.

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[8] Among women age 15-44 who have ever had sex with a man, 98.6% of Catholic women, 99.4% of women who are Baptist or affiliated with other fundamentalist Protestant sects, 99.5% of women affiliated with other Protestant denominations, and 99.4% of women with no religious affiliation have used contraception. Kimberly Daniels et al., *Contraceptive Methods Women Have Ever Used: United States, 1982–2010*, NAT'L HEALTH STAT. REP., Feb. 14, 2013, at 8, *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf.

[9] Lawrence B. Finer & Mia R. Zolna, *Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008*, 104 Am. J. Pub. Health S43, S44 (2014), *available at* https://www.guttmacher.org/pubs/journals/ajph.2013.301416.pdf.

[10] *Id.*

A. Providing Women with No-Cost Access to the Full Range of Contraceptive Methods Reduces Their Risk of Unintended Pregnancy.

1. Petitioners' amici claim "contraception is ubiquitous, widely used and relatively inexpensive."[11] Of course, one method—condoms—is widely and cheaply available. But having access to *some* method of contraception is far different from a woman consistently having access to the methods that she determines are most appropriate and effective for her at a given point in her life. The contraceptive coverage guarantee reflects this core reality.

On average, American women use three or four different methods of contraception by age 40.[12] Women choose among options based on their specific life circumstances, economic resources, health needs, personal beliefs, and other factors.[13] Some women choose long-acting, reversible contraceptives such as an implant or IUD.[14] Others obtain prescriptions for hormonal-based contraceptives, such as birth-control pills, or shots (known as "injectables") that are ad-

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[11] Amicus "Women Speak for Themselves" Br. 13, 16-20.

[12] Daniels et al., *supra* note 8, at 4-5.

[13] *See, e.g.*, RACHEL BENSON GOLD ET AL., GUTTMACHER INST., NEXT STEPS FOR AMERICA'S FAMILY PLANNING PROGRAM 7 (2009), *available at* https://www.guttmacher.org/pubs/NextSteps.pdf.

[14] Kimberly Daniels et al., *Current Contraceptive Use and Variation by Selected Characteristics Among Women Aged 15-44*, 86 NAT'L HEALTH STAT. REP., Nov. 10, 2015, at 4-7, *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr086.pdf.

ministered in the upper arm by a health care provider on a quarterly basis.[15] Still other couples use over-the-counter contraception, such as male condoms or spermicide.[16] Others choose a permanent method, either female or male sterilization.[17] And others attempt to avoid pregnancy by altering their sexual behavior, including through fertility-awareness-based contraception (where couples do not engage in sexual intercourse during certain periods of a woman's fertility cycle) or "withdrawal."[18]

Not only do women often change methods over time or in response to different life circumstances, but many use more than one method at the same time, e.g., using condoms as well as birth-control pills to protect against sexually transmitted diseases in addition to pregnancy.[19] A recent study that assessed the most common methods of contraception ever used by American women concluded that 93% had used male condoms, 82% had used oral contraceptives, and 60% had used withdrawal at some point in their lives.[20]

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[15] *Id.* at 4 fig.1.

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] Daniels et al, *supra* note 8, at 5; *see also* David L. Eisenberg et al., *Correlates of Dual-Method Contraceptive Use*, INFECTIOUS DISEASES IN OBSTETRICS & GYNECOLOGY, 2012, at 4-5, *available at* http://tinyurl.com/guym4zq.

[20] *See, e.g.*, Daniels et al., *supra* note 8, at 4, 11 tbl.1.

But some contraceptive methods are far more effective than others. IUDs and implants, for example, are effective for years after they are inserted by a health care provider and do not require women using them to think about contraception on a day-to-day basis.[21] By contrast, birth control pills should be taken each day at approximately the same time. Nearly half of users of birth-control pills who obtained abortions reported that they had forgotten to take their pills, and another quarter reported a lack of ready access to their pills (16% were away from their pills and 10% ran out).[22] Methods of contraception designed to be used during intercourse, such as condoms or spermicide, must be available, accessible, remembered, and used properly each time intercourse occurs.

In addition, methods such as male condoms and withdrawal require the active and effective participation of male partners at the time of sexual intercourse. By contrast, methods such as IUDs, implants, and oral contraceptives can be more reliably used by the woman alone in advance of intercourse.[23]

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[21] Brooke Winner et al., *Effectiveness of Long-Acting Reversible Contraception*, 366 NEW ENG. J. MED. 1998, 1999 (2012), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMoa1110855 (noting that long-acting reversible contraceptives' failure rates "rival those with sterilization").

[22] Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 294, 300 tbl.6 (2002), *available at* https://www.guttmacher.org/pubs/journals/3429402.pdf.

[23] Martha J. Bailey, *More Power to the Pill*, 121 Q. J. ECON. 289, 295-96 (Feb. 2006), *available at* http://tinyurl.com/Bailey-

Extensive empirical evidence establishes what one would expect: these variations in contraceptive methods and real-world practices translate directly into variable effectiveness. As reflected in the table below, IUDs and implants boast remarkably low failure rates compared to male condoms, while contraceptive methods such as withdrawal and fertility awareness have high failure rates over the first year of typical use.

Contraceptive Method	Failure Rate Based on First Year of Typical Use[24]
Implant	0.05%
Hormonal IUD	0.2%
Copper IUD	0.8%
Injectables	6%
Oral contraceptives	9%
Male condoms	18%
Withdrawal	22%
Fertility-awareness-based contraception	24%
Spermicide	28%

PowerToPill (recognizing the significance of oral contraceptives as compared to prior-available contraceptive methods because they "divorced the decision to use contraception from the time of intercourse").

[24] *See* ROBERT A. HATCHER ET AL., CONTRACEPTIVE TECHNOLOGY tbl.3-2 (20th ed. 2011); *see also* Winner et al., *supra* note 21, at 1999.

This chart vividly illustrates that use of different methods of contraception has an enormous impact on the rate of unintended pregnancy. Compared with reliance on the hormonal IUD (with a failure rate of 0.2%), a couple relying on condoms is *90 times as likely to have an unintended pregnancy* in the first year of use, and a couple relying on oral contraceptives is 45 times as likely.

Of course, this reflects the average effectiveness among women using each method. Some women and their partners are more successful at consistently and correctly using a method than others. There are many reasons beyond ease of use why method choice matters, and why choice helps women use their method most effectively. For example, women's contraceptive method choices are influenced by concerns about side effects and drug interactions, other health needs, how frequently they expect to have sex, their perceived risk of sexually transmitted infections, whether their male partners are fully and consistently supportive of contraceptive use, and the nature of their intimate relationship(s).

One key factor influencing the effectiveness of contraception is a woman's satisfaction with her choice of method. Those who are not satisfied are more likely to use the method inconsistently and increase their risk of unintended pregnancy; one study found that 30% of neutral or dissatisfied users had a

gap in use, compared with 12% of completely satisfied users.[25]

These contraceptive failures have far-reaching consequences for women, families, and society. Approximately half of all pregnancies in the United States are unintended—that is, over three million pregnancies each year.[26] About half of all American women will experience an unintended pregnancy.[27] Forty percent of unintended pregnancies end in abortion,[28] and nearly one-third of American women will have an abortion at some point in their lives.[29]

2. A woman's access to the full range of contraceptive methods—methods of widely varying effectiveness and appropriateness for her—has a huge impact on her risk of unintended pregnancy. And a woman's choice among the various available contraceptive methods is significantly constrained by cost.

Contrary to petitioners' suggestion, extensive empirical evidence establishes what common sense

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[25] Jennifer J. Frost et al., Guttmacher Inst., *Improving Contraceptive Use in the United States*, IN BRIEF, April 2008, at 4, *available at* http://tinyurl.com/gr9uoya.

[26] Finer & Zolna, *supra* note 9, at S44.

[27] Stanley K. Henshaw, *Unintended Pregnancy in the United States*, 30 FAM. PLAN. PERSP. 24, 24 (1998), *available at* https://www.guttmacher.org/pubs/journals/3002498.pdf.

[28] Finer & Zolna, *supra* note 9, at S44.

[29] Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 OBSTETRICS & GYNECOLOGY 1358, 1366 (2011), *available at* http://tinyurl.com/hexcnwj.

would suggest: Reducing (and even better, eliminating) the cost of contraception leads to more effective and continuous use of contraception.[30] The contraceptive methods that can be purchased over the counter at a neighborhood drugstore for a comparatively low cost—male condoms and spermicide—are far less effective than methods with a higher up-front cost,[31] which require a prescription and a visit to a health care provider.[32]

The most effective methods are long-acting reversible contraception, such as implants and IUDs. Even with discounts for volume, the cost of these devices exceeds $500, exclusive of costs relating to the insertion procedure,[33] and the total cost of initiating one of these methods generally exceeds $1000.[34] To put that cost in perspective, beginning to use one of these devices costs nearly a month's salary for a

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[30] *See infra* nn.37-48.

[31] James Trussell et al., *Cost Effectiveness of Contraceptives in the United States*, 79 CONTRACEPTION 5, 10 (2009).

[32] HATCHER ET AL., *supra* note 24.

[33] ERIN ARMSTRONG ET AL., INTRAUTERINE DEVICES AND IMPLANTS 13-15 figs.3-6 (2d ed. 2015), *available at* http://tinyurl.com/z2vqycr.

[34] David Eisenberg et al., *Cost as a Barrier to Long-Acting Reversible Contraceptive (LARC) Use in Adolescents*, 52 J. ADOLESCENT HEALTH S59, S60 (2013), *available at* http://www.jahonline.org/article/S1054-139X(13)00054-2/pdf.

woman working full time at the federal minimum wage.[35]

These costs are prohibitive for women not covered by the contraceptive coverage guarantee; one pre-ACA study concluded that only 25% of women who requested an IUD had one placed after learning the associated costs.[36] And women who faced high out-of-pocket IUD costs were significantly less likely to obtain an IUD than women with access to the device at low or no out-of-pocket cost.[37] Yet as explained above, these devices are dramatically more effective in preventing pregnancy than methods of contraception with lower up-front costs.[38] And contrary to suggestions from petitioners' amici,[39] they are also associated with particularly high rates of user satisfaction and continuation.[40]

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[35] The federal minimum wage is $7.25 an hour. 29 U.S.C. § 206(a)(1)(C). At 40 hours a week, that amounts to $290 a week, before any taxes or deductions.

[36] Aileen M. Gariepy et al., *The Impact of Out-of-Pocket Expense on IUD Utilization Among Women with Private Insurance*, 84 CONTRACEPTION e39, e40 (2011), *available at* http://escholarship.org/uc/item/1dz6d3cx.

[37] *Id.* at e41.

[38] James Trussell, *Update on and Correction to the Cost-Effectiveness of Contraceptives in the United States*, 85 CONTRACEPTION 611, 611 (2012).

[39] Amicus "Women Speak for Themselves" Br. 16-20. The HHS Program cited actually shows that use of IUDs increased by more than 500% over a 15-year period. *Id.*

[40] AM. COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION: INCREASING ACCESS TO CONTRACEPTIVE IMPLANTS AND INTRAUTERINE DEVICES TO REDUCE UNINTENDED

Even oral contraceptives, which are twice as effective as condoms in practice, require a prescription and substantial cost—a cost that is incurred month after month. And although some stores offer certain pill formulations at steep discounts, forcing a woman to change to a different formulation because of cost has the potential for serious adverse effects.

The essential point behind the contraceptive guarantee, of course, is not that any one method is right for every woman at all times in her long reproductive life, but that each woman should be able to choose the contraceptive method that is best for her and not be deterred by cost and access.

Without insurance coverage, the large up-front costs of the more effective methods deter women who otherwise would want to use them. In a study conducted prior to the contraceptive coverage guarantee, almost one-third of women reported that they would change their contraceptive method if cost were not an issue.[41] This figure was particularly high among women relying on male condoms and other less effective methods such as withdrawal.[42] Other

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PREGNANCY 1-2 (Oct. 2015), *available at* http://tinyurl.com/jcdwqrk; Megan L. Kavanaugh et al., *Changes in Use of Long-Acting Reversible Contraceptive Methods Among U.S. Women, 2009-2012*, 126 OBSTETRICS & GYNECOLOGY 917, 919-21 (Nov. 2015); HATCHER ET AL., *supra* note 24, at tbl.3-2.

[41] Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use, United States, 2004*, 40 PERSP. ON SEXUAL & REPROD. HEALTH 94, 98 (2008), *available at* https://www.guttmacher.org/pubs/journals/4009408.pdf.

[42] *Id.* at 99.

studies have found that uninsured women are less likely to use the most expensive, but most effective, contraceptive methods, such as IUDs, implants, and oral contraceptives,[43] and are more likely than insured women to report using no contraceptive method at all.[44]

Concerns relating to the cost of effective contraception are particularly acute for women experiencing financial hardship. In a survey of women with household incomes of less than $75,000, conducted at the height of the recession in summer 2009, nearly half of respondents noted that they wanted to reduce or delay their childbearing because of the economy, and 64% agreed with the statement: "With the economy the way it is, I can't afford to have a baby right now."[45] Unfortunately, many of the surveyed women also reported that financial constraints had caused them to cut corners with regard to contraception. Indeed, 23% reported a more difficult time affording contraception than in prior years.[46] For example, 25% of women who were struggling financially and

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[43] Kelly R. Culwell & Joe Feinglass, *The Association of Health Insurance with Use of Prescription Contraceptives*, 39 PERSP. ON SEXUAL & REPROD. HEALTH 226, 228 (2007), *available at* http://www.guttmacher.org/pubs/journals/3922607.pdf.

[44] *Id.*; *see also* Kelly R. Culwell & Joe Feinglass, *Changes in Prescription Contraceptive Use, 1995–2002*, 110 OBSTETRICS & GYNECOLOGY 1371, 1375-76 (2007).

[45] GUTTMACHER INST., A REAL-TIME LOOK AT THE IMPACT OF THE RECESSION ON WOMEN'S FAMILY PLANNING AND PREGNANCY DECISIONS 3 (2009), *available at* https://www.guttmacher.org/pubs/RecessionFP.pdf.

[46] *Id.* at 6.

used oral contraceptives had resorted to using contraception inconsistently as a means of saving money.[47]

3. Before the Affordable Care Act went into effect, twenty-eight states required private insurers that cover prescription drugs to provide coverage of most or all FDA-approved contraceptive drugs and devices.[48] These programs gave women access at lower prices than if contraception were not covered, but all states still allowed insurers to require cost-sharing. Experience from these states demonstrates that reducing financial barriers to health care access is key to increasing access to effective contraception.[49] Privately insured women living in states that

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[47] *Id.* at 5.

[48] Guttmacher Inst., *State Policies in Brief: Insurance Coverage of Contraceptives* 2 (Feb. 1, 2016), *available at* http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf.

[49] Petitioners inaccurately disparage as a "made-for-litigation theory" what in fact is a long-standing governmental commitment to promoting access to contraception. Petitioners' single citation to the contrary is made-for-litigation "science" that is rife with flaws and was published in a law review rather than in a peer-reviewed scientific journal. *See* ETBU Br. 60 n.7; *see also* Amicus Michael J. New Br. 5-17. As a consequence, the article's claim "that [state] mandates do not lower rates of unintended pregnancy or abortion" has never been subjected to the critical scientific peer-review process for vetting inaccuracies.

One basic flaw in petitioners' law review article is that none of the state contraceptive coverage laws eliminate out-of-pocket costs entirely, which is the major advance from the federal guarantee and the issue in this case. In addition, over the course of the period the article evaluated, many states enacted contraceptive coverage laws in quick succession. Adam Son-

required private insurers to cover prescription contraceptives were 64% more likely to use some contraceptive method during each month a sexual encounter was reported than women living in states with no such requirement, even after accounting for differences including education and income.[50]

Although these state policies reduced women's up-front costs, other actions to eliminate out-of-pocket costs entirely—which is what the federal contraceptive coverage guarantee has done for most privately insured women—have even greater potential to increase effective contraceptive use. For example, when Kaiser Permanente Northern California eliminated patient cost-sharing requirements for IUDs, implants, and injectables, the use of these devices increased substantially, with IUD use more than doubling.[51] Another example comes from a study of more than 9000 St. Louis-region women who were

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field et al., *U.S. Insurance Coverage of Contraceptives and the Impact of Contraceptive Coverage Mandates, 2002*, 36 PERSP. ON SEXUAL AND REPROD. HEALTH 72, 73 (2004), *available at* https://www.guttmacher.org/pubs/journals/3607204.pdf. Contraceptive coverage became the norm in the insurance industry—even in states without mandates—thus minimizing potential differences between states with laws and states without them. The article also mischaracterizes and misunderstands many of the state laws and does not account for other policies advancing access to contraception.

[50] Brianna M. Magnusson et al., *Contraceptive Insurance Mandates and Consistent Contraceptive Use Among Privately Insured Women*, 50 MED. CARE 562, 565 (2012).

[51] Debbie Postlethwaite et al., *A Comparison of Contraceptive Procurement Pre- and Post-Benefit Change*, 76 CONTRACEPTION 360, 363 (2007).

offered the reversible contraceptive method of their choice (i.e., any method other than sterilization) at no cost for two to three years, and were "read a brief script informing them of the effectiveness and safety of" IUDs and implants.[52] Three-quarters of those women chose long-acting methods (i.e., IUDs or implants), a level far higher than in the general population.[53] Likewise, a Colorado study found that use of long-acting reversible contraceptive methods quadrupled when offered with no out-of-pocket costs along with other efforts to improve access.[54]

Government-funded programs to help low-income people afford family planning services provide further evidence that reducing or eliminating cost barriers to women's contraceptive choices has a dramatic impact on women's ability to choose and use the most effective forms of contraception. Among women who obtain contraceptive services from publicly funded reproductive-health providers, 64% select hormone-based contraceptive methods, 11% use

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[52] Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291, 1292 (2012), *available at* http://tinyurl.com/hhttjhl.

[53] *See id.* at 1293.

[54] Sue Ricketts et al., *Game Change in Colorado: Widespread Use Of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women*, 46 PERSP. ON SEXUAL & REPROD. HEALTH 125, 128-29 (Sept. 2014), *available at* http://obgyn.wisc.edu/documents/Game_Change_in_Colorado_Rickets.pdf. Efforts to improve access included provider training and programs to ensure providers had all methods on hand.

implants or IUDs, and 8% use sterilization.[55] Studies estimate that without publicly supported access to these methods at low or no cost, more than half of those women would switch to male condoms or other non-prescription methods, and 30% would use no contraception at all.[56] This lack of access would result in a fivefold increase in the rate of unintended pregnancies among this group of women.[57]

In addition, a closer look at why the U.S. teen pregnancy rate fell by over 50% between 1990 and 2010 illustrates both the key role of contraception and refutes the argument by petitioners' amici that more contraceptive use leads to more sexual activity. The vast majority (86%) of the decline in teen pregnancy between 1995 and 2002 was the result of improvements in contraceptive use; only 14% can be

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[55] JENNIFER J. FROST ET AL., GUTTMACHER INST., CONTRACEPTIVE NEEDS AND SERVICES, 2010 19 (July 2013), *available at* https://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf.

[56] *Id.* Petitioners' amici seem to suggest, counter to strong empirical evidence and common sense, that eliminating cost for contraception does not reduce unintended pregnancy because "Unintended pregnancy rates . . . are in fact highest among women receiving free or low-cost contraception via government programs." Yet all that demonstrates is that publicly funded family planning care does not have sufficient resources to meet the need—and indeed, publicly funded providers met only an estimated 42% of the need for publicly supported contraceptive services and supplies in 2013. JENNIFER J. FROST ET AL., GUTTMACHER INST., CONTRACEPTIVE NEEDS AND SERVICES, 2013 UPDATE 10 (July 2015), *available at* http://www.guttmacher.org/pubs/win/contraceptive-needs-2013.pdf

[57] FROST ET AL., *supra* note 55, at 19-20.

attributed to a decrease in sexual activity.[58] The 2003-2010 teen pregnancy decline was due entirely to better contraceptive use. Notably, even though contraceptive use among teens increased significantly during this entire period, levels of teen sexual activity did not increase, and in fact decreased slightly during part of this period.[59]

In sum, ensuring the availability of the full array of contraceptive methods serves the government's compelling interest in empowering each woman to select the method that is best for her and preventing unnecessarily high incidence of unintended pregnancy and abortion.

B. Helping Women Avoid Unintended Pregnancy Improves Their Health, Reduces Their Need for Abortion, and Promotes Their Educational, Economic, and Social Advancement.

Providing women with the means to avoid unintended pregnancies yields enormous benefits to women, their families, and society.

1. The Centers for Disease Control and Prevention included the development of and improved access to methods of family planning among the ten great public health achievements of the 20th century because of its numerous benefits to the health of

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[58] Heather D. Boonstra, *What Is Behind the Declines in Teen Pregnancy Rates?*, GUTTMACHER POL'Y REV., Summer 2014, at 16, *available at* http://www.guttmacher.org/pubs/gpr/17/3/gpr170315.pdf.

[59] *Id.*

women and children.[60] This is a direct benefit that alone provides compelling reason for the contraceptive coverage guarantee.

By reducing abortion and unintended pregnancy, contraceptive use decreases pregnancy-related morbidity and mortality.[61] Moreover, "[a]n unintended pregnancy may have significant implications for a woman's health, sometimes worsening a preexisting health condition such as diabetes, hypertension, or coronary artery disease."[62] Effective family planning brings vital benefits for women with health conditions that heighten the risk of pregnancy and childbirth, and allows women with preexisting or underlying health conditions to plan the timing of pregnancy consistent with their health needs and medical care.[63]

Unintended pregnancy affects not only women's physical health but their mental health as well. Unintended pregnancy is a risk factor for depression,[64]

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[60] Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900-1999: Family Planning*, 48 MORBIDITY & MORTALITY WKLY. REP. 1073 (1999).

[61] MEGAN L. KAVANAUGH & RAGNAR M. ANDERSON, GUTTMACHER INST., CONTRACEPTION AND BEYOND 7-8 (2013), *available at* https://www.guttmacher.org/pubs/health-benefits.pdf.

[62] Hal C. Lawrence, III, Testimony Before the Institute of Medicine Committee on Preventative Services for Women, Jan. 12, 2011, at 11, *available at* http://tinyurl.com/ztyclx4.

[63] *See, e.g., id.*

[64] Albert L. Siu & US Preventive Services Task Force, *Screening for Depression in Adults*, 315 JAMA 380, 382 (2016), *available at* http://tinyurl.com/hhbnqe9.

and a recent study published in the American Journal of Public Health found that "unwanted pregnancies were strongly associated with poorer mental health outcomes in later life."[65]

Allowing women to better time and space their pregnancies also enables them to have healthier babies.[66] Closely spaced pregnancies are associated with increased risk of harmful birth outcomes, including preterm birth, low birth weight, stillbirth, and early neonatal death.[67]

2. Enabling women to avoid unintended pregnancies through access to effective and appropriate contraception serves another vital end: Reducing the rate of unintended pregnancy is the most effective and most widely acceptable way to reduce the need for and incidence of abortion.

The relationship between effective contraception and abortion rates is undeniable. The vast majority

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[65] Pamela Herd et al., *The Implications of Unintended Pregnancies for Mental Health in Later Life*, AM. J. PUB. HEALTH, Dec. 21, 2015, at e1.

[66] *See, e.g.*, KAVANAUGH & ANDERSON, *supra* note 61, at 8-10.

[67] Amanda Wendt et al., *Impact of Increasing Inter-Pregnancy Interval on Maternal and Infant Health*, 26 (Supp. 1) PAEDIATRIC & PERINATAL EPIDEMIOLOGY 239, 248 (2012), *available at* http://tinyurl.com/gnmvbxe; Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes*, 295 JAMA 1809, 1821 (2006), *available at* http://www.fsfb.org.co/sites/default/files/birthspacingandriskofadverse.pdf; Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health*, 39 STUD. FAM. PLAN. 18, 23-25 (2008).

of abortions are preceded by an unintended pregnancy and could be prevented by effective contraceptive use. In fact, the two-thirds of women at risk of unintended pregnancy who consistently and correctly practice contraception account for only 5% of unintended pregnancies.[68]

Contrary to speculation from some of petitioners' amici, extensive empirical data confirms that contraceptive use is a major factor in recent abortion declines.[69] The decline in the U.S. abortion rate between 2008 and 2011 was accompanied by a steep drop in the birthrate, indicating that pregnancy—and unintended pregnancy in particular—decreased. Over the same time period, overall use of contraceptives among women at risk of unintended pregnancies increased, while use of highly effective methods—such as the IUD and implant—more than tripled between 2007 and 2012.[70] This leads to the conclusion that improved contraceptive use, including use of highly effective methods, led to fewer unintended pregnancies and was likely the key driver of the abortion decline by helping to reduce women's need for abortion.

Dramatic evidence of the impact of effective contraception on the need for abortion can be found in the study of more than 9000 St. Louis-region women

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[68] SONFIELD ET AL., *supra* note 7, at 8 fig.1.3.

[69] Joerg Dreweke, *U.S. Abortion Rate Continues to Decline While Debate over Means to the End Escalates*, GUTTMACHER POL'Y REV., Spring 2014, at 3-4, *available at* http://www.guttmacher.org/pubs/gpr/17/2/gpr170202.pdf.

[70] Kavanaugh et al., *supra* note 40, at 919-21.

who were offered the reversible contraceptive method of their choice at no cost.[71] During the study period, the number of abortions performed at St. Louis Reproductive Health Services declined by 20%.[72] Study participants' abortion rate was significantly lower than the rate in the surrounding St. Louis region, and less than half the national average.[73] The study concluded that similar nationwide changes in contraceptive access could prevent more than half of abortions performed annually.[74]

Similarly, when Iowa simultaneously increased access to both contraception and abortion, the abortion rates actually declined.[75] Starting in 2006, the state expanded access to low- or no-cost family planning services through a Medicaid expansion and a privately funded initiative serving low-income women.[76] Use of long-acting reversible contraception rose significantly during that time.[77] Despite a simultaneous increase in access to abortion—the number of clinics offering abortions in the state actually doubled during the study period—the abortion rate

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[71] Peipert et al., *supra* note 52, at 1294-95.

[72] *Id.*

[73] *Id.*

[74] *Id.* at 1296.

[75] M.A. Biggs et al., *Did Increasing Use of Highly Effective Contraception Contribute to Declining Abortions in Iowa?*, 91 CONTRACEPTION 167, 169-71 (2015).

[76] *Id.* at 168.

[77] *Id.* at 169.

dropped by over 20%.[78] The data indicate that the increased use of long-acting reversible contraception throughout the state contributed to this decline in abortions, a reduction of over a thousand abortions a year.[79]

3. Effective family planning also promotes women's continued educational and professional advancement, contributing to the enhanced economic stability of women and their families.[80] The advent of widespread access to effective reversible contraception (starting with oral contraceptives) in the 1960s gave women far greater ability to plan for and delay pregnancy, and thereby allowed them to invest in higher education at a significantly higher rate. In fact, early access to oral contraceptives is estimated to account for one-third of the increase in women's college enrollment during the 1970s.[81] Another study estimated that the initial increase in access to the pill accounted for more than 30% of the historic increase in the proportion of women in skilled ca-

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[78] *Id.* at 168-69.

[79] *Id.* at 168-71.

[80] ADAM SONFIELD ET AL., GUTTMACHER INST., THE SOCIAL AND ECONOMIC BENEFITS OF WOMEN'S ABILITY TO DETERMINE WHETHER AND WHEN TO HAVE CHILDREN 3-5 (2013), *available at* http://www.guttmacher.org/pubs/social-economic-benefits.pdf.

[81] HEINRICH HOCK, THE PILL AND THE COLLEGE ATTAINMENT OF AMERICAN WOMEN AND MEN 19 (Oct. 9, 2007) (unpub. study, Fla. State Univ.), *available at* ftp://econpapers.fsu.edu/RePEc/fsu/wpaper/wp2007_10_01.pdf; *see also* Elizabeth Oltmans Ananat & Daniel M. Hungerman, *The Power of the Pill for the Next Generation*, 94 REV. ECON. & STAT. 37, 50 (2012).

reers from 1970 to 1990.[82]

A narrowing of the gender-based compensation gap soon followed. Indeed, one-third of the total wage gains for women born between the mid-1940s and mid-1950s is attributed to women's ability to reliably delay pregnancy through oral contraception.[83] Nor was oral contraceptives' impact limited to the years immediately following their widespread availability. Thirty-one percent of the narrowing of the gender-based hourly wage gap during the 1990s is attributed to oral contraceptives.[84] And one study estimated that as of 2000, more than 250,000 women had obtained a bachelor's degree because they could obtain contraception as late adolescents.[85]

The ability to prevent or delay pregnancy until after attaining educational, economic, and career goals remains critically important to American women.[86] The pill and other methods of contraception have been shown to enhance women's earning potential by enabling delayed childbearing, thereby allow-

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[82] Claudia Goldin & Lawrence F. Katz, *The Power of the Pill*, 110 J. POL. ECON. 730, 748-49 (2002), *available at* http://tinyurl.com/je44vsh.

[83] Martha J. Bailey et al., *The Opt-In Revolution? Contraception and the Gender Gap in Wages* (Nat'l Bureau of Econ. Research, Working Paper No. 17922, Mar. 2012), at 26, *available at* http://www.nber.org/papers/w17922.pdf.

[84] *Id.* at 27.

[85] HOCK, *supra* note 81, at 19.

[86] *See* Jennifer J. Frost & Laura Duberstein Lindberg, *Reasons for Using Contraception*, 87 CONTRACEPTION 465, 468 (2013).

ing young women to invest in education and obtain crucial early work experience in order to achieve greater income stability than those who started their families at a younger age.[87] As one study put it, "family planning programs may help break the cycle of poverty."[88]

As Judge Kavanaugh summarized, "[a]bout 50% of all pregnancies in the United States are unintended. The large number of unintended pregnancies causes significant social and economic costs. To alleviate those costs, the Federal Government has long sought to reduce the number of unintended pregnancies, including through the Affordable Care Act by making contraceptives more cheaply and widely available."[89] Consistent with common sense and the experiences of women and families, empirical evidence establishes that the federal contraceptive coverage guarantee serves a compelling government in-

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[87] Amalia R. Miller, *The Effects of Motherhood Timing on Career Path*, 24 J. POPULATION ECON. 1071, 1097 (2011); *see also* McKinley L. Blackburn et al., *Fertility Timing, Wages, and Human Capital*, 6 J. POPULATION ECON. 1, 23 (1993); David S. Loughran & Julie M. Zissimopoulos, *Why Wait? The Effect of Marriage and Childbearing on the Wages of Men and Women*, 44 J. HUM. RES. 326, 346 (2009) (explaining that the first birth of a child lowers female wages 2-3%); Hiromi Taniguchi, *The Timing of Childbearing and Women's Wages*, 61 J. MARRIAGE & FAM. 1008, 1014 (1999).

[88] Martha J. Bailey et al., *Do Family Planning Programs Decrease Poverty?*, 60 CESIFO ECON. STUDIES 312, author manuscript, at 3 (2014), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4206087/.

[89] *Priests for Life*, 808 F.3d at 22-23 (Kavanaugh, J., dissenting from the denial of reh'g en banc).

terest by providing women with the ability to access FDA-approved contraceptive methods with no out-of-pocket cost.

II. THE CONTRACEPTIVE COVERAGE GUARANTEE IS THE LEAST RESTRICTIVE MEANS OF REMOVING BARRIERS TO CONTRACEPTIVE ACCESS.

The government has given petitioners their choice of multiple ways to avoid paying for, administering, or otherwise facilitating their employees' use of contraception. An employer can opt out by sending a form to the plan's health insurer or third-party administrator (TPA). Or it can send a simple written notification of its objection to the government.[90] Alternatively, petitioners can avoid providing employer-sponsored health care *at all* for *less* than the cost of providing health coverage.[91]

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[90] *E.g.*, 26 C.F.R. § 54.9815-2713A; 29 C.F.R. §§ 2510.3-16, 2590.715-2713A; 45 C.F.R. § 147.131; U.S. Br. 14-15.

[91] If employers choose not to provide health care benefits to their employees directly—a lawful option—they must in some circumstances pay a "tax" that will help subsidize the government's provision of health care benefits. 26 U.S.C. § 4980H; *cf. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2597 (2012) (the "shared responsibility payment merely imposes a tax citizens may lawfully choose to pay in lieu of buying health insurance"). Although the penalties for providing an *incomplete* health care plan that omits contraceptive coverage may be high, the tax assessed for providing *no health care coverage at all* is roughly $2000 per employee per year (26 U.S.C. § 4980H). This is far less than the cost of providing health care benefits; employer contribution to health care coverage averaged $5179 per employee per year for single coverage in 2015. KAISER FAMILY FOUNDATION & HEALTH RESEARCH & EDUCATIONAL TRUST,

If an objecting employer opts out by notifying the government, its insurer, or its TPA, it has no obligation to provide contraceptive coverage. Instead, a third party makes separate payments for contraceptive services for the employees and their covered dependents. This coverage is provided by the same insurers and TPAs that administer the women's other health coverage, ensuring that women "continue to receive contraceptive coverage without cost sharing" and without "'logistical and administrative obstacles.'" *Hobby Lobby*, 134 S. Ct. at 2782 (citation omitted).

Petitioners insist, however, that the government should be precluded even from independently arranging with their plans' insurers or TPAs to offer contraceptive coverage. In particular, they protest notifying anyone of their religious objections and any use of their so-called plan "infrastructure" to facilitate reimbursement of contraceptive services to their employees.[92]

Petitioners object to the very things that would be necessary for the government and insurers/TPAs to identify, locate, and provide coverage to women who are denied contraceptive coverage by their em-

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EMPLOYER HEALTH BENEFITS: 2015 SUMMARY OF FINDINGS 2 Ex.C (2015), *available at* http://tinyurl.com/j3zjscz. This tax payment option alone dooms petitioners' claim. *See, e.g., United States v. Lee*, 455 U.S. 252, 258-60 (1982); *Hernandez v. C.I.R.*, 490 U.S. 680, 695 (1989).

[92] *See* U.S. Br. 37-40 (explaining that the accommodation does not use petitioners' "plan infrastructure" or require petitioners to authorize the provision of contraception).

ployers (or by the employers of their spouse or parent).[93] All the alternatives that petitioners propose would impose a burden on women to locate and obtain contraceptive coverage. This would harm a significant number of women and fundamentally frustrate the government's compelling interest.[94]

1. Petitioners hypothesize ways the government could set up and fully fund the entire cost of contraceptive coverage, so women could obtain coverage with merely a "de minimis administrative burden" of "taking a few minutes to sign up . . . for a separate insurance card."[95] Petitioners suggest that an "administrative burden" should not pose any barrier to women's access to contraception, and chastise the government for "apparently (and incorrectly) believ[ing] that women are so helpless and incapable that they can't take such small steps to obtain government-funded contraceptives on their own."[96]

Petitioners misunderstand the least restrictive means test. As other briefs explain, the government has no obligation under the Religious Freedom Restoration Act (RFRA) to set up and fund a new, alter-

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[93] U.S. Br. 87 (no alternative means by which the government could obtain the information).

[94] For nonprofits with over 1000 employees, a full 10% reported that they elected the accommodation. Laurie Sobel et al., *Data Note: Are Nonprofits Requesting an Accommodation for Contraceptive Coverage?*, KAISER FAMILY FOUNDATION, Dec. 1, 2015, at 2 fig.1, *available at* http://tinyurl.com/zjjh6gm.

[95] Zubik Br. 75.

[96] *Id.*; Priests for Life Pet. for Cert. Reply 12.

native program.[97] More basically, petitioners' claim that mere "administrative burdens" would not affect access to contraception is flatly and demonstrably wrong: Voluminous evidence establishes the ineffectiveness of policies that put the onus on participants. Numerous scientific studies—across genders and across subject matters—demonstrate that participation dramatically declines when people have to take even small administrative steps to participate.[98] Thus, even if the government did undertake to set up and fund programs to provide free contraception to all women, such a policy would fail to achieve the government's compelling interest.

Two examples illustrate how even simple administrative actions serve as a powerful barrier to participation. First, consider a workplace retirement savings plan such as a 401k. These plans provide significant tax savings, making them a highly desirable investment. Yet many employees do not take advantage of these plans when some action is required to begin participation. One study looked at three large companies, which had participation rates for new employees in 401k savings plans ranging

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[97] *See, e.g.*, U.S. Br. 76, 79-85.

[98] *E.g.*, Eric J. Johnson & Daniel Goldstein, *Do Defaults Save Lives?*, 302 SCIENCE 1338, 1338 (Nov. 2003), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1324774; Brigitte C. Madrian & Dennis F. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, 116.4 T. Q. J. ECON. 1149, 1149-50 (Nov. 2001), *available at* http://tinyurl.com/nnt333d.

from 26% to 43%.[99] After the government began allowing employers to automatically enroll employees in 401k plans, each company switched from an opt-in system to an opt-out system where employees would be enrolled unless they filled out a simple form opting out.[100] Once participation was the no-action default, new employee participation rates at all three companies shot up to over 85%.[101] Defaults matter greatly—a fact the government has understood for many years.[102]

Organ donation provides another illustration.[103] Some countries use an opt-in system that requires people to affirmatively consent to organ donation, often by checking a box on their driver's license application.[104] Other countries use an opt-out system that permits citizens to decline organ donation

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[99] James J. Choi et al., *For Better or For Worse: Default Effects and 401 (k) Savings Behavior*, Nat'l Bureau of Econ. Research (Dec. 2001), at 5, *available at* http://www.nber.org/papers/w8651.pdf.

[100] *Id.*

[101] *Id.* at 9-12; *see also* Madrian & Shea, *supra* note 98, at 1158-61 (documenting similar increase in retirement savings plans).

[102] *E.g.*, *Remarks of Treasury Secretary Lawrence H. Summers at the Department of Labor Retirement Savings Education Campaign Fifth Anniversary Event*, U.S. DEP'T OF THE TREASURY (July 18, 2000), https://www.treasury.gov/press-center/press-releases/Pages/ls785.aspx, at § II (explaining that modern behavioral research caused government to embrace opt-out system for retirement investments).

[103] Johnson & Goldstein, *supra* note 98, at 1138.

[104] *Id.*

through a similarly easy administrative action. If petitioners were correct that imposing a "de minimis administrative burden" should not affect participation rates, the choice of system should have little effect. But the default makes a huge difference in participation. Germany's opt-in system has a 12% participation rate, for instance, while neighboring Austria and Poland both have opt-out systems with over 99% participation rates.[105]

Nor can the government overcome the barriers posed by administrative hurdles through spending on public education and outreach—which, again, would depend upon new legislation that RFRA does not require. The Netherlands employed an extensive public education campaign to persuade its citizens to consent to organ donation, which included sending more than 12 million letters in a country of just 15.8 million residents.[106] The government's efforts did not budge the rate of opt-in participation from around 28%.[107] Meanwhile, neighboring Belgium's opt-out system has a 98% participation rate.[108]

2. In addition to the predictable ineffectiveness of an alternative that would shift the burden to women to locate and sign up for separate contraceptive coverage, petitioners' proposed alternatives have a host of other problems. These problems are ex-

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[105] *Id.*

[106] *Id.* at 1339.

[107] *Id.* at 1338-1339.

[108] *Id.*

plained thoroughly in other briefs,[109] but we highlight here a few of special concern.

a. Some alternatives could deny women the ability to obtain contraceptive counseling and services from their desired provider at the same time they receive other primary and preventive care.[110] A woman going to her gynecologist for an annual examination, for example, may have to go to a different provider to be prescribed (or even discuss) contraception. This disjointed approach increases the time and effort involved in getting needed contraception and interferes with her ability to obtain care from the provider of her choice.

Isolating contraceptive coverage in this way also would interfere with the ability of health care providers to treat women holistically. A woman's choice of contraception can be affected by her other medical conditions (e.g., diabetes, HIV, depression/mental health), and medications such as antibiotics can significantly reduce the effectiveness of some methods of contraception, so a woman's chosen provider must be able to manage all health conditions and needs at

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[109] *See, e.g.*, U.S. Br. 72-88; Amici Health Policy Experts Br. § 3.

[110] Lawrence Leeman, *Medical Barriers to Effective Contraception*, 34 OBSTETRICS & GYNECOLOGY CLINICS OF NORTH AM. 19, 19 (2007) (removing barriers to use of contraception and allowing women to begin their chosen method more quickly increases the use and effectiveness of contraception); DEP'T OF REPROD. HEALTH AND RESEARCH, WORLD HEALTH ORGANIZATION, SELECTED PRACTICE RECOMMENDATIONS FOR CONTRACEPTIVE USE 4-5 (2d ed. 2004), *available at* http://apps.who.int/iris/bitstream/10665/43097/1/9241562846.pdf.

the same time.[111] Moreover, some medical conditions such as endometriosis and polycystic ovary syndrome are treated with contraceptives; for these conditions the employer would have to give a "permission slip" for a woman to have coverage for the medication she needed for non-contraceptive reasons.

Finally, making women go to additional lengths to obtain contraceptive coverage and services would stigmatize contraceptive services, treating them as something other than—and less than—health care. Congress enacted the Women's Health Amendment out of a desire to ensure women had access to health care appropriate to their unique needs; requiring women to "enroll in new programs or to surmount other hurdles" to get contraceptive coverage would isolate, stigmatize, and burden that care.[112] Those additional burdens "could hardly be more inconsistent" with the government's desire to ensure that women have equal access to the health care they need.[113]

b. Contraception-only coverage—one of petitioners' proposed alternatives—is not currently available on the ACA's marketplaces, or anywhere else in the private insurance market. While the cost of providing contraceptive services through a group coverage

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[111] *See, e.g.*, CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE, 2010 (4th ed. 2010), *available at* http://tinyurl.com/zjsut2n.

[112] 80 Fed. Reg. 41,318, 41,328 (July 14, 2015); U.S. Br. 75.

[113] *Korte v. Sebelius*, 735 F.3d 654, 727 (7th Cir. 2013) (Rovner, J., dissenting) (footnote omitted).

plan is estimated to be less than $4 a month for each member (not counting any resulting savings),[114] the costs of a contraception-only plan, if offered, would be significantly higher because issuers will assume anyone purchasing a contraception rider will be using it.[115]

Numerous studies show it is cost-effective for private insurance plans to provide coverage of contraceptive services and supplies, because contraception prevents unintended pregnancies.[116] After accounting for both direct medical costs of pregnancy and indirect costs such as employee absence and reduced productivity, estimates suggest it costs employers 11-17% more *not* to provide contraceptive coverage in employee health plans than to provide such coverage.[117]

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[114] NAT'L BUS. GRP. ON HEALTH, INVESTING IN MATERNAL AND CHILD HEALTH 2:41 (2007), *available at* http://tinyurl.com/jpd9asd.

[115] Provision of maternity care provides a striking parallel. Before the ACA took effect, only 12% of individual plans included coverage for maternity services, and about half of those that did were from the handful of states that required maternity coverage under state law. DANIELLE GARRETT ET AL., NAT'L WOMEN'S LAW CENTER, TURNING TO FAIRNESS: INSURANCE DISCRIMINATION AGAINST WOMEN TODAY AND THE AFFORDABLE CARE ACT 11-13 (2012), *available at* http://tinyurl.com/7xqspu6. Another 7% of plans offered maternity coverage as a rider for additional cost, but it was often prohibitively expensive. *Id.* at 11.

[116] *E.g.*, James Trussell et al., *supra* note 31, at 5-6.

[117] Rowena Bonoan & Julianna S. Gonen, *Promoting Healthy Pregnancies*, WASH. BUS. GRP. ON HEALTH, FAM. HEALTH IN BRIEF, Aug. 2000, at 6; WILLIAM M. MERCER, WOM-

c. The proposed alternatives that involve cost-sharing or after-the-fact reimbursement to women would effectively reinstate the very cost barriers to contraceptive counseling, services, and supplies that the coverage guarantee is designed to eliminate.[118]

As explained above, increasing numbers of women prefer methods of contraception that are extremely effective but have high up-front costs, such as IUDs and implants.[119] Cost-sharing or reimbursement alternatives would hamper women's choice of those methods, and disadvantaged women would be affected the most—when facing economic hardship, people prioritize food and housing over health care.[120]

3. The federal government has long demonstrated its commitment to giving women access to family planning services and supplies as part of comprehensive insurance coverage. Congress has required the inclusion of contraceptive coverage under the

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EN'S HEALTH CARE ISSUES: CONTRACEPTION AS A COVERED BENEFIT 5 (2000).

[118] *See* Section I, *supra*.

[119] Kavanaugh et al., *supra* note 40, at 919-21.

[120] Margot B. Kushel et al., *Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans*, 21 J. GEN. INTERNAL MED. 71, 75-76 (Jan. 2006), *available at* http://tinyurl.com/jddzswq; Kristen W. Reid et al., *Association Between the Level of Housing Instability, Economic Standing and Health Care Access: A Meta-Regression*, 19 J. HEALTH CARE FOR THE POOR & UNDERSERVED 1212, 1218-25 (Nov. 2008).

health plans it sponsors for federal employees and their dependents for nearly 20 years.[121] And for over 40 years, federal law has required coverage of family planning services and supplies in the Medicaid program without any out-of-pocket costs for patients.[122] The government has a compelling and established interest in removing barriers to contraceptive access to benefit women, families, and society.

CONCLUSION

For the foregoing reasons, the Court should hold that RFRA does not require the new programs petitioners seek.

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[121] Treasury and General Government Appropriations Act, 2000, Pub. L. No. 106-58, § 635(a), 113 Stat. 430, 474.

[122] 42 U.S.C. §§ 1396d(a)(4)(C), 1396o(a)(2)(D).

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